Exhibit P

Part 1 of 2

UnitedHealthcare

United HealthCare Services, Inc.
DULUTH SERVICE CENTER
PO BOX 30884
SALT LAKE CITY, UT 84130-0884

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

October 09, 2019

DPS$$$PKG

00963715513

Member/Patient Information

Member:
Member ID: **00963715513**
Patient:
Relationship: CH
Group Name: WELLS FARGO
Group #: 0108000

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$2,800.00	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$522.54	**Your Plan Paid** The money your health benefit plan paid.
$2,277.46	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

S VS-03194*01*020182-MO-19282-09024-ACUS W22SYMS

UnitedHealthcare

United HealthCare Services, Inc.
DULUTH SERVICE CENTER
PO BOX 30884
SALT LAKE CITY, UT 84130-0884
Phone: 1-800-842-9722

October 09, 2019

Have more questions about your claim?
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for all your claim and benefit information.

Claim Detail for 00963715513

Provider: NEW LIFE TREATMENT **Claim Number:** AU8772758901 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
09/12/2018	OUTPATIENT SERVICES	CY	$2,800.00	$0.00	$870.90	$522.54	$0.00	$0.00	$348.36	$1,929.10	$2,277.46
Claim Total:		E5	**$2,800.00**	**$0.00**	**$870.90**	**$522.54**	**$0.00**	**$0.00**	**$348.36**	**$1,929.10**	**$2,277.46**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Notes*

CY - THIS PAYMENT HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE ELIGIBLE EXPENSE AMOUNT FOR OUT-OF-NETWORK SERVICES UNDER YOUR PLAN IN YOUR AREA. IF YOU ARE BILLED FOR AN AMOUNT ABOVE THE ELIGIBLE AMOUNT, PLEASE CALL VIANT DIRECTLY AT 1-800-598-6888.

E5 - ADDITIONAL CHARGES AND/OR CORRECTED BILLING HAS BEEN CONSIDERED.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 740816, Atlanta, GA 30374-0816. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review not later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Availability of Consumer Assistance/Ombudsman Services

UnitedHealthcare

United HealthCare Services, Inc.
DULUTH SERVICE CENTER
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SALT LAKE CITY, UT 84130-0884
Phone: 1-800-842-9722

October 09, 2019

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There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-800-842-9722.

Rather view this online?

Sign up for **myuhc.com** to easily view claims and account balances, see where you're at against your deductible, locate a network doctor, compare costs, select paperless delivery of your important plan documents and more.

Rather view this on your mobile device?

Download the free UnitedHealthcare Health4Me app, then sign up to easily find and map care, compare costs, view claims and account balances and more. Get access to the same personalized health plan information while you're on the go.

Maintaining the privacy and security of individuals' personal information is very important to us at UnitedHealthcare. To protect your privacy, we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier. You may see the unique individual identifier on UnitedHealthcare correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBs), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer care professional at the number shown at the top of this Statement.

Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you weren't treated fairly you can send a complaint to: Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608, Salt Lake City, UTAH 84130, UHC_Civil_Rights@uhc.com. You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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October 09, 2019

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You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

S VS-03194*03*020185-MO-19282-09024-ACUS W22SYMS

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UnitedHealthcare

October 09, 2019

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Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2018

00963715513

Relationship: CH

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$2,700.00	$2,700.00	Met
Out of Pocket	$5,200.00	$4,540.87	$659.13
OUT OF NETWORK			
Deductible	$5,400.00	$5,400.00	Met
Out of Pocket	$10,400.00	$9,273.28	$1,126.72

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$2,700.00	$2,700.00	Met
Out of Pocket	$5,200.00	$3,016.38	$2,183.62
OUT OF NETWORK			
Deductible	$5,400.00	$5,400.00	Met
Out of Pocket	$10,400.00	$8,276.23	$2,123.77

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Plan Year: The time period the benefit maximums apply.

Your Plan Paid: The money your health benefit plan paid.

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PO BOX 740800
ATLANTA, GA 30374-0800

Have more questions about your claim?
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for all your claim and benefit information.

December 31, 2021

DPS$$$PKG

00955375640

Member/Patient Information

Member/Patient:
Member ID: **00955375640**
Relationship: EE
Group Name: GENERAL DYNAMICS
Group #: 0217725

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$4,950.00	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$600.00	**Your Plan Paid** The money your health benefit plan paid.
$4,350.00	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

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PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-866-249-7571

December 31, 2021

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Claim Detail for 00955375640

Provider: HIGH WATCH RECOVERY
Provider Status: Out of Network

Claim Number: DC7993588401

Patient Account Number: [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
10/21/2021 - 10/26/2021	MEDICAL SERVICES	CY	$4,950.00	$0.00	$600.00	$600.00	$0.00	$0.00	$0.00	$4,350.00	$4,350.00
Claim Total:			**$4,950.00**	**$0.00**	**$600.00**	**$600.00**	**$0.00**	**$0.00**	**$0.00**	**$4,350.00**	**$4,350.00**

**This total does not reflect any payments / copays you made at the time of service or purchase.
Please wait for a provider bill before making a payment.

We received the requested information on **12/17/21** and have processed claim number **DA25259924001**.

Notes*

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Availability of Consumer Assistance/Ombudsman Services

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December 31, 2021

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Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
Telephone: 866-466-4446
Website: www.ct.gov/oha
E-mail: healthcare.advocate@ct.gov

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

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You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

UnitedHealthcare

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ATLANTA, GA 30374-0800
Phone: 1-866-249-7571

December 31, 2021

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

UnitedHealthcare

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Phone: 1-866-249-7571

December 31, 2021

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for all your claim and benefit information.

Account Summary

Summary of Deductible and Out of Pocket

Plan Year: 2021

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$3,000.00	$3,000.00	Met
Out of Pocket	$6,000.00	$6,000.00	Met
OUT OF NETWORK			
Deductible	$7,600.00	$7,600.00	Met
Out of Pocket	$20,800.00	$20,800.00	Met

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services. You generally pay less if you see a network provider.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Network: The facilities, providers and suppliers who do not have a contract with your health plan to provide health care services. You generally pay more if you see an out-of-network provider.

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Phone: 1-866-249-7571

December 31, 2021

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Definitions of Key Terms

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Year: The time period the benefit maximums apply.

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Your Plan Paid: The money your health benefit plan paid.

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Have more questions about your claim?
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for all your claim and benefit information.

April 20, 2021

00843696068

Member/Patient Information

Member:
Member ID: **00843696068**
Patient:
Relationship: SP
Group Name: GENERAL DYNAMICS
Group #: 0217725

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$25.00	**Amount Billed** The amount your provider charged for services provided to you.
$13.74	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$0.00	**Your Plan Paid** The money your health benefit plan paid.
$11.26	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

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April 20, 2021

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for all your claim and benefit information.

Claim Detail for 00843696068

Provider: OCEAN RADIOLOGY **Claim Number:** CP7742695001 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
03/25/2021	RADIOLOGY SERVICES	UG	$25.00	$13.74	$11.26	$0.00	$11.26	$0.00	$0.00	$0.00	$11.26
Claim Total:			**$25.00**	**$13.74**	**$11.26**	**$0.00**	**$11.26**	**$0.00**	**$0.00**	**$0.00**	**$11.26**

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Notes*

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UG - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. YOU HAVE NOT MET YOUR DEDUCTIBLE AND OWE THE AMOUNT SHOWN.

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There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. Your state consumer assistance program may also be able to assist you at:
Office of the Healthcare Advocate

UnitedHealthcare

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ATLANTA, GA 30374-0800
Phone: 1-866-249-7571

April 20, 2021

Have more questions about your claim?
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for all your claim and benefit information.

P.O. Box 1543
Hartford, CT 06144
Telephone: 866-466-4446
Website: www.ct.gov/oha
E-mail: healthcare.advocate@ct.gov

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Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you weren't treated fairly you can send a complaint to: Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608, Salt Lake City, UTAH 84130, UHC_Civil_Rights@uhc.com. You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-866-249-7571

April 20, 2021

Have more questions about your claim?
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We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2021

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$3,000.00	$2,906.56	$93.44
Out of Pocket	$6,000.00	$2,906.56	$3,093.44
OUT OF NETWORK			
Deductible	$6,000.00	$2,906.56	$3,093.44
Out of Pocket	$12,000.00	$2,906.56	$9,093.44

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PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-866-249-7571

April 20, 2021

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Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Plan Year: The time period the benefit maximums apply.

Your Plan Paid: The money your health benefit plan paid.

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April 26, 2021

DPS$$$PKG

00928097365

Member/Patient Information

Member/Patient:
Member ID: **00928097365**
Relationship: EE
Group Name: GEICO CORPORATION
Group #: 0755393

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$13,065.00	**Amount Billed** The amount your provider charged for services provided to you.
$985.50	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$1,032.27	**Your Plan Paid** The money your health benefit plan paid.
$11,047.23	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

S VY-01536*01*010046-MO-21116-81131-ACUS W42SYMS

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Phone: 1-855-434-2684

April 26, 2021

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Claim Detail for 00928097365

Provider: M NEMRI **Claim Number:** CP9161093701 **Patient Account Number:** 00928097365

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
04/02/2021	MEDICAL SERVICES	IX	$1,095.00	$985.50	$109.50	$76.65	$0.00	$0.00	$32.85	$0.00	$32.85
Claim Total:			**$1,095.00**	**$985.50**	**$109.50**	**$76.65**	**$0.00**	**$0.00**	**$32.85**	**$0.00**	**$32.85**

**This total does not reflect any payments / copays you made at the time of service or purchase.
Please wait for a provider bill before making a payment.

Claim Detail for 00928097365

Provider: ARISE RECOVERY **Claim Number:** CP6866010801 **Patient Account Number:** 00928097365

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
03/22/2021 - 03/25/2021	MEDICAL SERVICES	CY	$5,985.00	$0.00	$682.59	$477.81	$0.00	$0.00	$204.78	$5,302.41	$5,507.19
Claim Total:			**$5,985.00**	**$0.00**	**$682.59**	**$477.81**	**$0.00**	**$0.00**	**$204.78**	**$5,302.41**	**$5,507.19**

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Claim Detail for 00928097365

Provider: ARISE RECOVERY **Claim Number:** CP9226234801 **Patient Account Number:** 00928097365

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
03/29/2021 - 04/01/2021	MEDICAL SERVICES	CY	$5,985.00	$0.00	$682.59	$477.81	$0.00	$0.00	$204.78	$5,302.41	$5,507.19
Claim Total:			**$5,985.00**	**$0.00**	**$682.59**	**$477.81**	**$0.00**	**$0.00**	**$204.78**	**$5,302.41**	**$5,507.19**

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Notes*

Please note that appeal deadlines have been extended until further notice due to COVID-19. You should consult with your employer and visit the US Department of Labor website at dol.gov for more information and additional notices about the deadline extensions and how they may apply to you.

CY - THIS PAYMENT HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE ELIGIBLE EXPENSE AMOUNT FOR OUT-OF-NETWORK SERVICES UNDER YOUR PLAN IN YOUR AREA. IF YOU ARE BILLED FOR AN AMOUNT ABOVE THE ELIGIBLE AMOUNT, PLEASE CALL VIANT DIRECTLY AT 1-800-598-6888.

IX - THIS OUT-OF-NETWORK PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE BASED ON A FEE NEGOTIATED WITH MULTIPLAN/VIANT. IF YOU HAVE PAID THE PROVIDER MORE THAN THE AMOUNT YOU OWE, PLEASE CALL THEM FOR A REFUND.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432, Salt Lake City, UT 84130-0432. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

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Texas Department of Insurance
Consumer Protection (111-1A)
P.O. Box 149091
Austin, TX 78714-9091
Toll-free telephone: 1-800-252-3439
Fax: 1-512-490-1007
Web site: www.texashealthoptions.com
E-mail: ConsumerProtection@tdi.texas.gov

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-855-434-2684.

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Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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April 26, 2021

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Account Summary

Summary of Deductible and Out of Pocket

Plan Year: 2021

00928097365

Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$125.00	$125.00	Met
Out of Pocket	$2,100.00	$867.50	$1,232.50
OUT OF NETWORK			
Deductible	$700.00	$700.00	Met
Out of Pocket	$5,200.00	$1,609.08	$3,590.92

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$250.00	$125.00	$125.00
Out of Pocket	$4,200.00	$897.50	$3,302.50
OUT OF NETWORK			
Deductible	$2,100.00	$700.00	$1,400.00
Out of Pocket	$15,600.00	$1,609.08	$13,990.92

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

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Plan Year: The time period the benefit maximums apply.

Your Plan Paid: The money your health benefit plan paid.

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September 19, 2019

DPS$$$PKG

00920520108

Member/Patient Information

Member/Patient:
Member ID: **00920520108**
Relationship: EE
Group Name: TESLA
Group #: 0715316

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$14,000.00	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$1,973.05	**Your Plan Paid** The money your health benefit plan paid.
$12,026.95	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

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September 19, 2019

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Claim Detail for 00920520108

Provider: NEW LIFE TREATMENT **Claim Number:** 799026912001 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
08/29/2019 - 08/30/2019	MEDICAL SERVICES	CY	$5,600.00	$0.00	$789.22	$789.22	$0.00	$0.00	$0.00	$4,810.78	$4,810.78
Claim Total:			**$5,600.00**	**$0.00**	**$789.22**	**$789.22**	**$0.00**	**$0.00**	**$0.00**	**$4,810.78**	**$4,810.78**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Claim Detail for 00920520108

Provider: NEW LIFE TREATMENT **Claim Number:** 799026911901 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
08/28/2019	MEDICAL SERVICES	CY	$2,800.00	$0.00	$394.61	$394.61	$0.00	$0.00	$0.00	$2,405.39	$2,405.39
Claim Total:			**$2,800.00**	**$0.00**	**$394.61**	**$394.61**	**$0.00**	**$0.00**	**$0.00**	**$2,405.39**	**$2,405.39**

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Claim Detail for 00920520108

Provider: NEW LIFE TREATMENT **Claim Number:** 799026912101 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
09/02/2019 - 09/03/2019	MEDICAL SERVICES	CY	$5,600.00	$0.00	$789.22	$789.22	$0.00	$0.00	$0.00	$4,810.78	$4,810.78
Claim Total:			**$5,600.00**	**$0.00**	**$789.22**	**$789.22**	**$0.00**	**$0.00**	**$0.00**	**$4,810.78**	**$4,810.78**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Notes*

CY - THIS PAYMENT HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE ELIGIBLE EXPENSE AMOUNT FOR OUT-OF-NETWORK SERVICES UNDER YOUR PLAN IN YOUR AREA. IF YOU ARE BILLED FOR AN AMOUNT ABOVE THE ELIGIBLE AMOUNT, PLEASE CALL VIANT DIRECTLY AT 1-800-598-6888.

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Availability of Consumer Assistance/Ombudsman Services
There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. Your state consumer assistance program may also be able to assist you at:

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Phone: 1-844-255-3062

September 19, 2019

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California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921
TDD Number: 1-800-482-4TDD (4833)
http://www.insurance.ca.gov/

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-844-255-3062.

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Rather view this on your mobile device?

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UnitedHealthcare

United HealthCare Services, Inc.
CHICO SERVICE CENTER
PO BOX 30555
SALT LAKE CITY, UT 84130-0555
Phone: 1-844-255-3062

September 19, 2019

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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September 19, 2019

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Account Summary

Summary of Deductible and Out of Pocket

Plan Year: 2019

00920520108

Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Out of Pocket	$1,500.00	$1,500.00	Met
OUT OF NETWORK			
Deductible	$1,000.00	$1,000.00	Met
Out of Pocket	$3,000.00	$3,000.00	Met
CUSTOMER NETWORK			
Out of Pocket	$1,500.00	$1,500.00	Met

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Out of Pocket	$3,000.00	$1,500.00	$1,500.00
OUT OF NETWORK			
Deductible	$2,000.00	$1,000.00	$1,000.00
Out of Pocket	$6,000.00	$3,000.00	$3,000.00
CUSTOMER NETWORK			
Out of Pocket	$3,000.00	$1,500.00	$1,500.00

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Plan Year: The time period the benefit maximums apply.

Your Plan Paid: The money your health benefit plan paid.

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August 23, 2018

DPS$$$PKG

00903502669

Member/Patient Information

Member/Patient:
Member ID: **00903502669**
Relationship: EE
Group Name: FIDELITY INVESTMENTS
Group #: 0119174

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$8,315.00	**Amount Billed** The amount your provider charged for services provided to you.
$6,156.16	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$2,008.84	**Your Plan Paid** The money your health benefit plan paid.
$150.00	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, co-pay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

Fidelity INVESTMENTS

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ATLANTA, GA 30374-0800
Phone: 1-800-331-0265

August 23, 2018

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Claim Detail for 00903502669

Provider: EXCEPTIONAL **Claim Number:** 730280021301 **Patient Account Number:** 00903502669

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
08/13/2018	OP MISC. SERVICES	CY	$3,780.00	$3,000.00	$630.00	$630.00	$0.00	$150.00	$0.00	$0.00	$150.00
08/13/2018	OP MISC. SERVICES	CY	$3,385.00	$2,466.16	$918.84	$918.84	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$7,165.00**	**$5,466.16**	**$1,548.84**	**$1,548.84**	**$0.00**	**$150.00**	**$0.00**	**$0.00**	**$150.00**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Claim Detail for 00903502669

Provider: A KHAN **Claim Number:** 730279297401 **Patient Account Number:** 00903502669

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
08/13/2018	OP MEDICAL VISIT	IX	$700.00	$432.70	$267.30	$267.30	$0.00	$0.00	$0.00	$0.00	$0.00
08/13/2018	SURGERY	IX	$450.00	$257.30	$192.70	$192.70	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$1,150.00**	**$690.00**	**$460.00**	**$460.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

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Notes*

CY - THIS PAYMENT HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE ELIGIBLE EXPENSE AMOUNT FOR OUT-OF-NETWORK SERVICES UNDER YOUR PLAN IN YOUR AREA. IF YOU ARE BILLED FOR AN AMOUNT ABOVE THE ELIGIBLE AMOUNT, PLEASE CALL VIANT DIRECTLY AT 1-800-598-6888.

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IX - THIS PHYSICIAN OR HEALTH CARE PROVIDER IS OUT-OF-NETWORK. BASED ON A FEE NEGOTIATED AGREEMENT WITH MULTIPLAN/VIANT, THE PROVIDER HAS ACCEPTED A DISCOUNT FOR THIS SERVICE. THE DISCOUNT SHOWN IS YOUR SAVINGS AND IS NOT INCLUDED IN THE AMOUNT YOU OWE. IF YOU HAVE PAID THE PHYSICIAN OR HEALTH CARE PROVIDER MORE THAN THE AMOUNT YOU OWE, PLEASE CALL THEM FOR A REFUND.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432, Salt Lake City, UT 84130-0432. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

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Texas Department of Insurance
Consumer Protection (111-1A)
333 Guadalupe
P.O. Box 149091
Austin, TX 78714
Toll-free telephone: 1-800-252-3439
Web site: www.texashealthoptions.com
E-mail: ConsumerProtection@tdi.texas.gov

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-800-331-0265.

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Rather view this on your mobile device?

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Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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ATLANTA, GA 30374-0800
Phone: 1-800-331-0265

August 23, 2018

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DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

Account Summary

Summary of Deductible and Out of Pocket

Plan Year: 2018

00903502669

Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$300.00	$0.00	$300.00
Out of Pocket	$1,500.00	$153.46	$1,346.54
OUT OF NETWORK			
Deductible	$600.00	$600.00	Met
Out of Pocket	$3,000.00	$2,186.40	$813.60
QUALITY/EFFICIENCY			
Out of Pocket	$1,500.00	$153.46	$1,346.54

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$600.00	$5.77	$594.23
Out of Pocket	$3,000.00	$190.75	$2,809.25
OUT OF NETWORK			
Deductible	$1,200.00	$600.00	$600.00
Out of Pocket	$6,000.00	$2,186.40	$3,813.60
QUALITY/EFFICIENCY			
Out of Pocket	$3,000.00	$190.75	$2,809.25

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

S WM-12177*03*078422-MO-18235-12233-AFUS 22SYCP

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Phone: 1-800-331-0265

August 23, 2018

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Definitions of Key Terms

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

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Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Year: The time period the benefit maximums apply.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Your Plan Paid: The money your health benefit plan paid.

S VT-08500*01*054107-MO-19240-65154-ACUS W21S PS

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SALT LAKE CITY, UT 84130-0555

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August 28, 2019

DPS$$$PKG
[redacted]

Member/Patient Information

Member/Patient: [redacted]
Member ID:
Relationship: EE
Group Name: APPLE INC.
Group #: 0700406

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$2,156.25	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$203.78	**Your Plan Paid** The money your health benefit plan paid.
$1,952.47	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

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August 28, 2019

Have more questions about your claim?
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for all your claim and benefit information.

Claim Detail for CASEY SCHULTHEIS

Provider: SUMMIT ESTATE **Claim Number:** 795249968901 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
07/29/2019	MEDICAL SERVICES	CY	$2,156.25	$0.00	$291.12	$203.78	$0.00	$0.00	$87.34	$1,865.13	$1,952.47
Claim Total:			**$2,156.25**	**$0.00**	**$291.12**	**$203.78**	**$0.00**	**$0.00**	**$87.34**	**$1,865.13**	**$1,952.47**

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Notes*

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Because your family's out-of-pocket maximum has been satisfied, your remaining individual out-of-pocket maximum has been adjusted to **$0**.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 740816, Atlanta, GA 30374-0816. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review not later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Availability of Consumer Assistance/Ombudsman Services

UnitedHealthcare

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August 28, 2019

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California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921
TDD Number: 1-800-482-4TDD (4833)
http://www.insurance.ca.gov/

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

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Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

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請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

UnitedHealthcare

United HealthCare Services, Inc.
RICHARDSON/SPRGFLD SRVC CNTR
PO BOX 30555
SALT LAKE CITY, UT 84130-0555
Phone: 1-866-348-1286

August 28, 2019

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2019

[redacted]

Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$300.00	$300.00	Met
Out of Pocket	$2,000.00	$1,821.75	Met
OUT OF NETWORK			
Deductible	$600.00	$600.00	Met
Out of Pocket	$4,000.00	$1,821.75	$2,178.25
CUSTOMER NETWORK			
Out of Pocket	$2,000.00	$1,821.75	Met

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$900.00	$900.00	Met
Out of Pocket	$4,000.00	$4,000.00	Met
OUT OF NETWORK			
Deductible	$1,800.00	$1,200.00	$600.00
Out of Pocket	$8,000.00	$4,481.70	$3,518.30
CUSTOMER NETWORK			
Out of Pocket	$4,000.00	$4,000.00	Met

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Plan Year: The time period the benefit maximums apply.

Your Plan Paid: The money your health benefit plan paid.

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August 28, 2019

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S WU-02029*01*012773-MO-19226-65154-ACUS W22S PS

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for all your claim and benefit information.

August 14, 2019

[redacted]

Member/Patient Information

Member/Patient: [redacted]
Member ID: [redacted]
Relationship: EE
Group Name: APPLE INC.
Group #: 0700406

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$2,156.25	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$203.78	**Your Plan Paid** The money your health benefit plan paid.
$1,952.47	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

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August 14, 2019

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

Claim Detail for [redacted]

Provider: SUMMIT ESTATE **Claim Number:** 793057983401 **Patient Account Number:** [redacted]

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
07/01/2019	MEDICAL SERVICES	CY	$2,156.25	$0.00	$291.12	$203.78	$0.00	$0.00	$87.34	$1,865.13	$1,952.47
Claim Total:			**$2,156.25**	**$0.00**	**$291.12**	**$203.78**	**$0.00**	**$0.00**	**$87.34**	**$1,865.13**	**$1,952.47**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Notes*

CY - THIS PAYMENT HAS BEEN REDUCED BY THE AMOUNT THAT IS ABOVE THE ELIGIBLE EXPENSE AMOUNT FOR OUT-OF-NETWORK SERVICES UNDER YOUR PLAN IN YOUR AREA. IF YOU ARE BILLED FOR AN AMOUNT ABOVE THE ELIGIBLE AMOUNT, PLEASE CALL VIANT DIRECTLY AT 1-800-598-6888.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 740816, Atlanta, GA 30374-0816. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review not later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Availability of Consumer Assistance/Ombudsman Services
There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789. Your state consumer assistance program may also be able to assist you at:
California Department of Insurance

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August 14, 2019

Have more questions about your claim?
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Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll-Free Consumer Hotline: 1-800-927-HELP (4357) or 1-213-897-8921
TDD Number: 1-800-482-4TDD (4833)
http://www.insurance.ca.gov/

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-866-348-1286.

Rather view this online?

Sign up for **myuhc.com** to easily view claims and account balances, see where you're at against your deductible, locate a network doctor, compare costs, select paperless delivery of your important plan documents and more.

Rather view this on your mobile device?

Download the free UnitedHealthcare Health4Me app, then sign up to easily find and map care, compare costs, view claims and account balances and more. Get access to the same personalized health plan information while you're on the go.

Maintaining the privacy and security of individuals' personal information is very important to us at UnitedHealthcare. To protect your privacy, we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier. You may see the unique individual identifier on UnitedHealthcare correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBs), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer care professional at the number shown at the top of this Statement.

Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you weren't treated fairly you can send a complaint to: Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608, Salt Lake City, UTAH 84130, UHC_Civil_Rights@uhc.com. You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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August 14, 2019

Have more questions about your claim?
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You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

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PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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August 14, 2019

Have more questions about your claim?
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Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2019

[redacted]

Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$1,500.00	$1,500.00	Met
Out of Pocket	$2,000.00	$1,827.23	$172.77
OUT OF NETWORK			
Deductible	$1,500.00	$1,500.00	Met
Out of Pocket	$4,000.00	$1,827.23	$2,172.77

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$3,000.00	$1,500.00	$1,500.00
Out of Pocket	$4,000.00	$1,827.23	$2,172.77
OUT OF NETWORK			
Deductible	$3,000.00	$1,500.00	$1,500.00
Out of Pocket	$8,000.00	$1,827.23	$6,172.77

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

Plan Year: The time period the benefit maximums apply.

Your Plan Paid: The money your health benefit plan paid.

S VS-10200*01*064885-MO-19225-65154-ACUS W21SYMS

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for all your claim and benefit information.

August 13, 2019

DPS$$$PKG
PAUL MILLEA
6790 STEPHAN CT
GILROY CA 95020-6718

Member/Patient Information
Member/Patient: PAUL MILLEA
Member ID: A903573655
Relationship: EE
Group Name: APPLE INC.
Group #: 0700406

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$19,406.25	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$1,818.08	**Your Plan Paid** The money your health benefit plan paid.
$17,588.17	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.